Support for Self Care in General Practice and Urgent Care Settings A Baseline Study

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Support for Self Care in General Practice & Urgent Care Settings – A Baseline Study

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Support for self care in general practice & urgent care settings

EXECUTIVE SUMMARY

There is considerable national and international evidence to show that supporting self care results in health benefits for the people and therefore overall gain for the care system. The opportunity for supporting self care is especially substantial in general practice and urgent care settings where 50 to 75% of attendances are for minor health incidents and a large proportion of which could potentially be handled by people themselves in their own homes. However, there appear to be barriers in these settings to support self care.

A qualitative survey using semi-structured interviews was carried out in general practice and urgent care settings principally to identify the barriers to supporting self care but also to assess the level of current self care support activity in these settings. This would help understand how self care support can be enhanced in the care system and also indicate the baseline activity with which to compare any changes in the future.

KEY MESSAGES FROM THE SURVEY

- There is a high level of support among general practice and urgent care staff for the NHS policy of supporting and promoting self care. All staff identified scope for increasing self care, particularly around minor ailments and health maintenance. But a number of barriers to further increasing support for self care were identified.
- Self care is a term that staff interpret in different ways and the extent to which clinicians' consultations routinely include self care support appears highly variable.
- General practice managers and clinicians may underestimate the amount of self care related work being done in general practice or urgent care settings because not all relevant work is identified as such.
- The general practice and urgent care settings studied did not have organisational policies or protocols for supporting self care. Staff training in self care was not widespread. Self care skills training for the staff needs to be viewed as priority in personal development plans (pdp) and continuing professional development (cpd).
- Self care skills training for the public is viewed as a priority by front line staff in achieving more self care among people.
- There are examples of good practice that could be spread more widely and act as models or starting points for others to adopt.

- Care of minor ailments is carried out in different ways in general practice, depending on a practice's decisions about the allocation of GP and nurse time. GP involvement in consultations for minor ailments is highly variable.

- A small number of clinicans in both settings routinely discuss and recommend use of the internet to patients.

- Information leaflets are used in general practice, particularly on minor ailments. However many clinicians expressed uncertainty about provision of information in leaflets produced externally.

- Referrals to self care support resources were reported more frequently by general practice clinicians, particularly nurses, than by staff in urgent care settings.

- Community pharmacies were generally regarded as potentially having a greater role to play in supporting self care. Greater integration of and joint working with pharmacists will be required if this potential is to be fulfilled.

KEY BARRIERS TO INCREASING SELF CARE SUPPORT AND SELF CARE IN GENERAL PRACTICE AND URGENT CARE SETTINGS

Impact of Access targets and improved availability of services

The most commonly cited barrier to getting people to do more self care was the ready availability of accessible self care support services in primary care and A&E. While they supported the principle of access targets, clinicians and managers said that paradoxically the targets led to increase in consultations often for what they perceived as 'inappropriate' attendance and hence patients did less self care. This also creates tension for staff who see the access target as potentially undermining their own efforts to promote appropriate use of services including support for self care.

The need to handle demand is a barrier to introducing new ideas

In both general practice and urgent care settings dealing with demand was a priority which in the view of many precluded investing resources in promoting and supporting future self care.

Need to increase public awareness

There were doubts about public's receptivity to the idea of self care. The need for a national campaign to raise public awareness was mentioned by several participating services.

Need for a national effort to provide self care skills training for the public

General practice staff felt that the responsibility for designing and providing patient education and skills training needed to be shared between the practice, primary care organisations and the DH.

While the internet was seen as a key information and educational resource some staff said that there was a need to provide the public with skills training on use of the internet.

Patient expectations

For Walk in Centre and A&E staff patient expectations were an important barrier to supporting self care. It was thought that patients would find it unacceptable to be sent away without a treatment, or to be sent somewhere else (eg to a community pharmacy).

The effect of attitudes and ways of working of health professionals

For most clinicians, once the patient was in consultation there was a tendency to deal with the immediate problem. There was evidence that some clinicians did use consultation styles that included discussing self care routinely. But health professionals themselves were also cited as a barrier in that they might have difficulty in sharing or handing over care.

Organisation-based approaches to self care support

None of the practices or urgent care settings took an organisation-based approach to providing self care support. Instead individuals had developed to varying levels their own approaches and on own initiative had found out about resources to support self care. Even during the short discussions they had ideas about actions they might take in the practice to do this. They had not received any self care skills training and this made it more difficult to make the links between their wider knowledge and possible future practice policies.

Services did not have a protocol or policy relating to self care support, advice and referrals. Sharing of information and practice around self care support seems most likely to happen in an ad hoc way.

Formal records of support, advice and referrals relating to self care are not currently kept. Without any templates, a barrier to recording is clinicians' concern about how much detail might be required and thus the time that might have to be spent on it.

The practices' patient surveys did not include questions about self care. Although there might be the facility to add questions to the surveys eligible for QOF this had not occurred for self care. Overall practice staff reported almost no feedback from patients about their use of self care support.

Need for self care knowledge, skills and training for staff

Training on self care skills was rarely reported in either general practice or urgent care settings, although its potential importance was recognised. A lack of pathways for self care was also reported as an issue, with implications for consistency of care between different practitioners.

In A&E a barrier was skills and knowledge of staff to enable discharge of the patient with self care advice and without them being seen by a doctor or advanced nurse practitioner.

Emergency Nurse Practitioners' knowledge of minor ailments was seen as a potential barrier to self care support in that it was variable and in some cases might not be strong.

Developing and extending the roles of staff

Community pharmacists were mentioned by urgent care staff as potentially useful contacts but with some training needs relating to local protocols. Staff in A&E perceive that currently patients may sometimes be referred to A&E unnecessarily by community pharmacists. Suggested ways of addressing this included joint working between A&E with the Local Pharmaceutical Committee and further training for pharmacists in specific conditions.

There is considerable enthusiasm in general practice to develop the role of Health Care Assistants (HCAs) in providing greater support for self care. There were two perceived barriers to making more effective use of HCAs' interactions with patients. The first is an apparent lack of relevant training. The second was the question of relevant role models. Practice nurses are actively involved in training HCAs and one method used is for the HCA to observe the nurse's consultations. While this is useful, the consultations are not necessarily of the nature or at the level that HCAs need to work. The general view was that there is need for developing clearer roles for HCAs and of which supporting self care may be an important part.

Economic aspects

There was tension among staff who felt that patients could treat many conditions themselves but there was reluctance to advise them on purchasing medicines, especially when the patient did not pay prescription charges. Some attendances at A&E as well as general practice were identified as being due to patients being unable or unwilling to buy treatment over the counter.

CURRENT PROVISION OF SELF CARE SUPPORT

Support for self care in general practice and urgent care settings is provided in a number of ways including:

- Practice waiting rooms are used to display posters and leaflets, some of which are about self care.
- Walk in Centres reported having a wide range of information leaflets available about specific conditions
- A&E departments had leaflets about subsequent care of specific injuries
- Practices have policies for the handling of consultations for minor and self-limiting ailments, where some consultations include self care advice or referrals to self care support facilities.

- Individual clinicians try to incorporate advice about self care into consultations, particularly in relation to minor and self-limiting ailments.
- Self care skills training about long term conditions is often provided in general practice on a one to one basis by nurses. Also referrals are being made to training courses such as the generic course provided in the Expert Patients Programme, or the disease specific courses such as Dafne, Desmond, D-STEP and LAD for people with diabetes.
- The facility to print patient information leaflets is available in certain consultations.
- Health Care Assistants, in registering new patients, may apply a template to ask about specific aspects of lifestyle and either provide advice or refer to another self care support facility.
- There are specific clinics in general practice, for example in weight management and smoking cessation which provide self care advice and/or self care skills training.
- Some clinicians provide access to self care support facilities such as self monitoring devices and technologies or self care equipment.
- Some clinicians provide information about patient organisations and self care support networks.

Support for self care in general practice & urgent care settings

FULL REPORT

There is considerable national and international evidence to show that supporting self care results in health benefits for the people and therefore overall gain for the care system. The opportunity for supporting self care is especially substantial in general practice and urgent care settings where 50 to 75% of attendances are for minor health incidents and a large proportion of which could potentially be handled by people themselves in their own homes[1]. However, there appear to be barriers in these settings to support self care.

A qualitative survey using semi-structured interviews was carried out in general practice and urgent care settings principally to identify the barriers to supporting self care but also to assess the level of current self care support activity in these settings. This would help understand how self care support can be enhanced in the care system and also indicate the baseline activity with which to compare any changes in the future.

1. OBJECTIVES AND METHOD OF SURVEY

The objectives of the qualitative survey were to establish a baseline on self care related activities in general practice and urgent care settings and to:

1. Explore clinicians' and managers' awareness of self care support activities generally and locally
2. Investigate ways in which practitioners' current practice supports self care; whether providing an integrated self care support resource, a fully fledged strategy, or some ad hoc support for self care
3. Explore the extent to which self care is offered as a choice to patients by the professionals
4. Explore the frequency of referrals made by practitioners to local programmes and services that support self care
5. Observe the ways in which general practice premises (particularly waiting areas) are used to support self care.

Twenty six Interviews were conducted between September 2005 and May 2006 (20 with general practice staff and 6 with staff in urgent care settings). There were face to face interviews with 5 GPs, 4 practice nurses, 2 Nurse Practitioners, 1 clinical pharmacist, 2 Health Care Assistants, 4 practice managers/practice administrators from four practices. Telephone interviews were conducted with 6 staff working in A&E and Walk in Centres.

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[1] 50% of attendances in general practice and 75% in A&E are for minor health incidents as reported by an expert panel working on patient flows across the whole system of care. Also see *Self Care - A Real Choice, Self Care Support - A Practical Option* (2005), Department of Health, at www.dh.gov.uk/selfcare

DESCRIPTION OF THE GENERAL PRACTICES

Practice 1 is located in the high street of a small town. A PMS practice which opened in spring 2003; the list size has grown from 1800 (inherited from a retiring single handed GP) to over 5000 and is still increasing. The practice has 3.5 WTE GPs, 2.2 WTE nursing staff (clinical sessions), and one Health Care Assistant.

The entrance to the practice contains a large leaflet rack with room for around 20 A5 size leaflets. The waiting room has two wall-mounted digital electronic signs - a 'Patient call-in board' linked to the practice computer which displays the patient and practitioner name for the next appointment, and a second display which shows around 10 messages, several relating to self care. These included *"Are you interested in joining the Expert Patients Programme? Ask at reception"* and *"Are you a carer? Ask for your carer goodie bag at reception"*. The waiting room has two large noticeboards, one with photographs and information about services provided by the practice nurse and Health Care Assistant; the other with a health education display on travel health and care in the sun.

The practice operates a telephone triage system for appointment requests provided by an Advanced Nurse Practitioner each morning. Around 50% of requests are dealt with by telephone advice on self care. Patients who need to be seen are offered an appointment with a nurse but can see a doctor if they wish. The nurse often provides self care support in terms of advice, information, access to self care devices or local networks. The advanced nurse practitioner is qualified as an Extended Formulary Nurse Prescriber.

Practice 2 is located in a small village in a semi-rural area. The practice dispenses medicines for 40% of its 6,400 registered patients and 89% of items are exempt from NHS charges. There are x GPs, one practice nurse and one Health Care Assistant.

The waiting room has a display board and leaflet racks. The planning and development of information provision in the waiting room, a new role, will be a responsibility of the Health Care Assistant.

The practice nurse's main area of work is care of people with long term conditions and this may be extended to minor ailments in the future. The practice's part time Health Care Assistant also continues to work as a part time receptionist . She has been developing the role, with mentoring from the practice nurse, during the last year. All minor ailments are currently dealt with by the GPs within the standard appointments system.

Practice 3 is located in a new town that was established in 1999. At the beginning of 2004 the practice had 2,500 patients registered, with a high proportion of young families. The reception and waiting area has a range of displays and leaflets. The practice is co-located with the local library in purpose-built premises. A Health Information Point is available next to the practice waiting area.

There are two practice nurses whose work encompasses consultations for minor ailments, although not in specific minor ailment clinics. They are not currently involved in clinics for the care of people with long term conditions but this is under review and likely to happen in the future. The practice has a clinical pharmacist who sees patients with minor ailments and with long term conditions. She is qualified as a supplementary prescriber and prescribes within an agreed care plan for each patient. She sees the practice's patients with heart disease and diabetes who are prescribed multiple medicines. She provides a range of self care support, such as linking patients to local self care support networks; and working collaboratively with the local library, issuing information prescriptions for patients to help them access self care information from the library.

Practice 4 is located on the edge of a town centre. The practice is GMS with a list size of 11,150. There are 4.5 GPs, one nurse practitioner, 6 practice nurses and one Health Care Assistant.

The entrance area has a notice board near to the reception desk with a display "Who can help me best?" which is part of the practice's signposting to different professionals and services.

Alongside GP sessions the practice operates an 'Express Clinic' and a Nurse Practitioner clinic. The Express Clinic deals mainly with straightforward and minor ailments. Patients requesting an appointment are signposted by the receptionist following an initial enquiry about the reason for the appointment. Two of the three nurses involved with the Express Clinic are qualified as Extended Formulary Nurse Prescribers; these nurses provide self care support to patients with minor ailments.

The waiting room is large with several display boards and leaflet racks. One display illustrates the sorts of problems that can be dealt with in the Express Clinic. A digital electronic sign is mounted on one of the display boards and shows general health and self care messages.

INTERVIEW METHODOLOGY

Individuals who were interviewed were asked about their work in the Practice, Walk in Centre or A&E Department and to give a brief profile of the sorts of patients they saw. They were asked what the term 'self care' meant to them, and about the ways in which their work involved support for self care. Practice and individual clinicians' recommendation of information and other provisions to support self care were explored. Referrals to different types of self care support facilities were discussed. Participants were asked what training they had received in self care. Practice systems such as protocols and record keeping relating to self care were explored. A key area that was covered was the participants' views on barriers in the services to support self care and barriers among patients to do more self care.

In the Findings sections that follow verbatim quotes are used to illustrate particular issues. Participants are coded as follows:

GP = General Practitioner
NP = Nurse Practitioner
PN = Practice Nurse
PCP = Practice Clinical Pharmacist
HCA = Health Care Assistant
PM = Practice Manager
UCM = Unscheduled Care Manager
WiCC = Walk in Centre Clinician
AEC = A&E Clinician
AEM = A&E Manager

2. FINDINGS OF THE QUALITATIVE SURVEY

BARRIERS TO INCREASING SELF CARE SUPPORT

Impact of Access targets and improved availability of services

There is a high level of support among staff for an NHS policy of promoting self care. However the most commonly cited barrier to getting people to do more self care was the readily available and easily accessible services in primary care and A&E. In general practice the access target was seen as contributing to increased public expectations and service use, and consequently less self care:

"It (the target) makes more people come for appointments" (GP2)

"They will come in now rather than treat themselves" (PM2)

"Ease of access has paradoxically made it (attending for self limiting illness) worse" (GP3)

"We've had an increase in the average number of appointments – but half the people we don't need to see" (GP1)

In urgent care settings the same issue was raised by all of the participating services:

"They can work against each other (targets and trying to increase self care) – people don't have to think for themselves if they can easily get someone else to think it through" (AEC1)

"The government brought in the 4 hour target – people know they can access care quicker – why wouldn't you come along?" (UCM2)

"You build that place (a WiC), you're providing an option. They (patients) will not self care if there is a facility that means they don't need to self care." (UCM1)

"We're (WiC) hugely accessible – people happen to be passing so they call in" (UCM3)

There was also the suggestion that patients might actively bypass their GP but would still want to see a nurse.

"….wouldn't bother a GP but are happy to see a nurse (at the WiC)" (UCM3)

Thus while they supported the principle of access targets, clinicians and practice managers said that paradoxically the targets often lead to patients justifying their seeking an appointment that the clinician may view as 'inappropriate', and also for that reason patients did less self care. This created tension for staff who see access targets as potentially undermining their own efforts to promote appropriate use of services, and did not encourage them to make efforts to promote different options including self care support services.

"We did a survey at the door (of the WiC) and asked people what they would have done if we weren't there – 40% said they would have made an appointment to see their GP, 33% would have gone to A&E but 25% said they would have coped themselves. We've generated additional demand" (UCM1)

Priority to instantly manage demand is a barrier to introducing new ideas

In both general practice and urgent care settings dealing with demand was a priority and staff were preoccupied by simply keeping up with demand so that considering self care as an option became a low priority which in the view of many precluded investing resources in promoting and supporting future self care.

"People are getting caught up too much in the process of processing patients" (AEC1)

This was particularly the case in A&E and Walk in Centres, where staff are dealing with a flow of walk-in clients expecting to be seen as quickly as possible.

Need to increase public awareness

There were doubts about public's receptivity to the idea of self care. The need for a national campaign to raise public awareness was mentioned by several participants.

"There's been a definite fall-off in self sufficiency. They say 'Is this x?' and when the answer is yes they're happy to go away" (GP1)

The need for providing enhanced self care skills training for the public

Another key barrier identified was the need for self care skills training for the public. Effective self care skills training among the public was viewed by clinicians and managers as essential and a way to potentially achieve more effective use of clinician time and NHS services. However, clinicians also identified the need for reassurance about what to do as a key driver of consulting behaviour, particularly among mothers of young children.

Also practice staff felt that the responsibility for designing and providing patient education and skills training needed to be shared between the practice, and centrally with DH and primary care organisations.

"There's a dual responsibility – the GP plus centrally with DH or the PCT" (GP3)

"We're not saying 'we don't want you here' but there's a need to re-skill patients" (PM2)

"Each consultation should be an educational opportunity to encourage people to look after themselves" (AEC1)

"Teaching people that when they attend they are expected to also do something for themselves, for example, reading the leaflet" (GP5)

Self care skills training was also seen as a possibility of changing long-established beliefs and behaviours that people had grown up with, but lack of resources was seen as a barrier that could make supporting self care costly .

"It's the less educated who are more likely to attend earlier" (GP3)

"It's not cost effective for us to do patient education" (GP1)

Participating services had a number of suggestions for methods of reaching the public including TV based services, information in posters in the practice, giving more self care information when new patients join the practice and including a leaflet on self care when the annual 'Routes to treatment' information is sent out.

"It has to start back at grass roots – run programmes in schools" (UCM3)

"What people perceive they're going to get (at A&E) – to see a more senior doctor – "I need to go to the hospital" – that needs education and a rethink" (AEC2)

One practice nurse had cosnidered holding an evening group session on diet but

"We cover a large area and people would have to travel long distances at night. Also we have a massive social spread – what level to talk to people? I need to learn how to assess people's level" (PN2)

Another practice had experimented with evening group meetings for patients but found they were not well attended and so stopped.

Few clinicians said they asked about access to the internet, or recommended its use to patients. Concerns were expressed about the quality and content of internet based information. Although the internet was seen as a key information and educational resource some staff said that there was a need to provide the public with skills training on use of the internet. Also lack of access to the internet for some patients hampered its potential.

<u>Public expectations</u>

Walk in Centre and A&E staff identified patient expectations as an important barrier to supporting self care. Having attended one service, it was thought that patients would find it unacceptable to be sent away

without a treatment, or to be sent somewhere else (eg to a community pharmacy). For most clinicians in all settings, once the patient had attended there was a tendency to simply deal with the current problem. Some comments suggested that staff might find it difficult, when a patient had attended where self care could have been an option, to discuss this in a way that the patient would not construe as negative or critical.

*"We do see a lot of minor ailments – but you don't want them to feel bad about coming back to you" (*PN4)

"If you said (to a patient) . . you've managed to find your way to the hospital but now you need to go to the pharmacy to get the medicine – you don't want to be sent from one place to another" (UCM2)

The effect of attitudes and ways of working of health professionals

For most clinicians in all settings, once the patient had attended there was a tendency to simply deal with the current problem. There was evidence that some clinicians did use consultation styles that included discussing self care routinely. Others thought that even bringing up the subject of self care might be interpreted by the patient as an implied criticism or accusation that they were attending unnecessarily.

Health professionals themselves were also cited as a barrier in that they might have difficulty in sharing or handing over care:

"It's tempting for health professionals to take over and say I'll look after you" (AEC1)

Differing professional approaches were also seen as an issue:

"We've got emergency nurse practitioners, paramedics, physios, junior doctors and GPs all working under the same roof. A diversity of people with different viewpoints and professional perspectives " (AEC1)

Organisation-based approaches to self care support

Practice and urgent care teams did not appear to have an organisation-based approach to providing self care support. Instead individuals on their own initiative had developed their own approaches and resources to support self care and had also found out about other resources in the community and elsewhere. Practice managers could see the potential benefits from increasing self care. Even during the short course of the discussions they had ideas about actions they might take in the practice to do this, but they had not received any training about self care and this made it more difficult to make the links between their wider knowledge and possible future practice policies.

Services did not have a protocol or policy relating to self care support, advice and referrals. Sharing of information and practice around self care

support currently seems most likely to happen in an ad hoc way if, for example, the topic of self care is raised during a practice meeting.

Formal records of advice and referrals relating to self care are not currently kept. This seemed to be something which clinicians had not previously considered.

"Education for patients with long term conditions is on a one to one basis and not recorded" (NP1)

One GP cited an example of recording but this was for exceptional circumstances:

"I record it where there are any medico-legal implications, as a safeguard" (GP3)

Without any templates, a barrier to recording is the clinicians' concern about how much detail might be required and thus the time that might have to be spent on it. Depending on which GP computer system is used the template may have a box to check to say that for example 'self care skills training' (unspecified) has been provided. The use of templates was suggested by one participant:

"We could use a template to monitor and add to" (NP1)

Currently practices have no way of knowing how much and what self care support and recommendations have been provided.

The practices' patient surveys did not include questions about self care. Although there might be the facility to add questions to the surveys eligible for QOF this had not occurred for self care. Overall practice staff reported almost no feedback from patients about their use of self care support.

<u>Need for self care knowledge, skills and training for staff</u>

There were only few examples of staff being trained in the principles and practice of support for self care.

In A&E a barrier was skills and knowledge of staff to enable discharge of the patient with self care advice without them being seen by a doctor or advanced nurse practitioner.

"They don't necessarily have the skills and knowledge to discharge patients with follow up advice" (UCM2)

"I'm not aware of any extra training on this (self care) for our staff" (UCM2)

Emergency Nurse Practitioners' knowledge of minor ailments was seen as a potential barrier in that it was variable and in some cases might not be strong.

*"Our ENPs' knowledge of minor ailments wasn't particularly good – we tried to improve this by having a GP in the (A &E) department – it's been really successful" (*UCM2)

This A&E department had hired a GP for a trial period of up to 12 months.

The scope of minor ailments was perceived as being wider and more challenging than minor injuries, with implications for the amount and type of training needed:

"Minor injuries are very easy and circumscribed, whereas minor ailments are more difficult" (AEC1)

A lack of pathways for self care was also reported as an issue, with implications for consistency of care between different practitioners and the need for skills

<u>Developing and extending the roles of staff</u>

Most participating services thought that community pharmacists potentially had a greater role to play in supporting self care. However they were largely isolated from both general practice and urgent care teams. This meant there were no opportunities to discuss patient care with the result that there were different referral thresholds and expectations. In urgent care settings there were some reported attempts to get patients to use their local pharmacy. However this strategy had been questioned because of concerns about the appropriateness of referrals by local community pharmacists. The perception was that pharmacists were sometimes overly cautious:

"They (the patient) say the chemist told me to come. The nurses say that sometimes pharmacists send people with conditions where it's not needed." (UCM1)

"Pharmacists send patients to us (WiC), for example with a normal histamine reaction to a bite, that they think might be infected (but isn't). I'd like to do some work with local pharmacists to try to address this" (UCM3)

There was some uncertainty about how confident community pharmacists felt when dealing with certain conditions, leading to increased likelihood of a referral that staff felt was unnecessary. Staff in A&E perceive that patients may sometimes be referred to A&E unnecessarily by community pharmacists.

"Depends on whatever their (the pharmacist's) comfort zone and level of confidence is. Rashes, for example, and lack of experience of some pharmacists" (UCM1)

Another issue that might reduce confidence in recommending use of pharmacies was that staff in urgent care settings were unsure about what sort of information and advice would have been given.

"I don't know that pharmacists necessarily ask the patient if they've already been taking regular analgesia, or tell them to try this for 24 hours" (UCM3)

The overall effect had been that some staff were reluctant to encourage patients to use the pharmacy since they thought that most would be referred to the WiC anyway. Staff generally indicated that community pharmacists were potentially useful contacts but with some training needs relating to local protocols. Suggested ways of addressing this included joint working between A&E with the Local Pharmaceutical Committee and further training for pharmacists in specific conditions (for example, when self care is sufficient for a minor injury versus when referral for further treatment is needed). These actions were thought likely to result in more completed episodes of care and support for self care by community pharmacists.

There is considerable enthusiasm to develop the role of Health Care Assistants (HCAs) in providing greater support for self care. There were two perceived barriers to making more effective use of HCAs' interactions with patients. The first appears to be a lack of relevant training. The second was the question of relevant role models. Practice nurses are actively involved in training HCAs and one method used is for the HCA to observe the nurse's consultations. While this is useful, the consultations are not necessarily of the nature or at the level that HCAs need to work. The general view was that there is a need to develop clearer roles for HCAs and of which supporting self care may be an important part.

<u>Economic aspects</u>

Financial barriers were also mentioned as barriers. Some attendances at A&E as well as general practice were identified as being due to patients being unable or unwilling to buy treatment over the counter. There was tension among staff who felt that patients could treat many conditions themselves but there was reluctance to advise them on purchasing medicines, especially when the patient did not pay prescription charges. The issue of which patients should be encouraged or told to buy treatment themselves was a sensitive one.

"I have concerns about people attending because medicines are free, for example, Calpol" (UMC3)

"Yes cost is a barrier but people don't come to A&E to get medicines because they can't afford them – it's more likely to be because they've run out of their prescription" (AEC2)

"The availability of products over the counter has improved, like chloramphenicol – but cost can be a problem, like £25 for emergency contraception" (PCP1)

CURRENT PROVISION OF SELF CARE SUPPORT

What self care support includes

Self care is a term that general practice staff interpreted in different ways.

"Avoiding going to hospital or the GP – looking after yourself" (PM2)

"Teaching patients to take care of their own self limiting illness and long term conditions" (GP3)

"Educating people to take responsibility for themselves" (NP1)

"It starts with a partnership-based approach to the consultation" (GP5)

When asked what the term self care meant to them many participants felt clear on the general meaning but there was less clarity on how self care featured systematically in their own practice, with a few exceptions.

"In my role in care of people with long term conditions it's about being aware of triggers - It's about educating people on the why not just what to do" (PN2)

"Asking about diet when they come for their INR appointment - you're asking them if they're taking care of themselves" (PN3)

"It's about helping patients to understand so they do what they can, It's nice to be able to say to somebody – "you've done well" when they've lost weight and there's no need to increase the dose of their medicines!" (PCP)

Practice managers and clinicians probably underestimate the amount of self care related work being done at practice level because not all relevant work is identified as such.

"We may be doing a lot already but I'm not sure we're doing anything under that name (self care)" (PM1)

Support for self care in general practice and urgent care settings is provided in a number of ways including:

- Practice waiting rooms are used to display posters and leaflets, some of which are about self care.
- Walk in Centres reported having a wide range of information leaflets available about specific conditions
- A&E departments had leaflets about subsequent care of specific injuries

- Practices have policies for the handling of requests for consultations for minor and self-limiting ailments, some of which may include self care advice or referrals to self care support facilities.
- Individual clinicians try to incorporate advice about self care into consultations, particularly in relation to minor ailments.
- Self care skills training about long term conditions is often provided in general practice on a one to one basis by nurses. Also information leaflets are provided about or referrals are made to training courses such as the generic course provided in Expert Patients Programme, or the disease specific courses such as Dafne, Desmond, D-STEP and LAD for people with diabetes[2].
- Printing of patient information leaflets is available in certain types of consultations.
- Health Care Assistants, in registering new patients, may apply a template to ask about specific aspects of lifestyle and either provide advice or refer to another self care support facility.
- There are specific clinics, for example in weight management and smoking cessation which provide self care advice and/or self care skills training.
- Some clinicians provide access to self care support facilities such as self monitoring devices and technologies or self care equipment.
- Some clinicians provide information about patient organisations and self care support networks.

The table below shows the resources & approaches of four general practices.

	Practice 1	Practice 2	Practice 3	Practice 4
Nurse or pharmacist led minor ailment clinics		✓		
Nurse and pharmacist minor ailment consultations				✓
Health Care Assistant(s)	✓	✓	✓	✓
Receptionist signposting		✓	✓	✓
Use of PRODIGY / EMIS leaflets	✓	✓	✓	✓
Use of practice-designed leaflets			✓	✓
Active engagement with generic EPP		✓		
Use of other self care skills training courses such as Dafne, Desmond, D-STEP and LAD for people with diabetes[2]				✓
Information prescriptions				✓

[2] Dafne: Dose adjustment for normal eating (for Type 1 diabetes)
Desmond: Diabetes (Type 2) education & self management for ongoing and newly diagnosed
D-STEP: Diabetes structured education programme
LAD : Learning about diabetes

Clinician involvement in supporting self care

Summary

Clinicians in general practice and urgent care settings identified minor ailments as a key area in which self care support could be increased.

Telephone triage for appointment requests in general practice was reported to result in around half of calls being resolved through self care advice only.

Clinicians had different views about the extent to which they could incorporate self care into their own consultations. Some targeted particular consultations, particularly for self-limiting conditions. Some provided support in terms of advice on taking up a self care skills training courses such as the generic Expert Patients Programme course, or disease specific courses such as Dafne, Desmond, D-STEP or LAD for people with diabetes; self care information, access to self care devices and equipment; or information on local self care support networks.

In those practices with nurse led clinics for the care of people with long term conditions, the GPs tended to see nurse input as being the main mechanism through which self care was supported for long term conditions especially in terms of the type of support mentioned above.

Practices are actively developing the roles of nurses and Health Care Assistants with the intention of redistributing certain areas of work previously done by GPs. Patient education to transfer consultations to these other practitioners is ongoing and viewed as a long-term process. The acceptability of appointments with someone other than the GP was reported to be variable. While some patients have accepted the developing services, practices report that others continue to insist on seeing the doctor.

In three of the four practices much of the routine care of people with single long term conditions such as asthma and diabetes is done by nurses. Tasks that were traditionally the domain of practice nurses (blood pressure measurement, ECGs, taking bloods, new patient checks) have been redistributed to Health Care Assistants to varying levels in all four practices.

Self-limiting illness is taken care of in different ways by practices, depending on practices' decisions about the allocation of GP and nurse resource. The practices operated different models. One model was that GPs saw all patients with self-limiting illnesses, with nurse resource allocated to the care of people with long term conditions. Another was telephone triage conducted by an advanced nurse practitioner, together with a limited number of nurse-led clinics. Telephone triage for appointment requests was reported to result in around half of calls being resolved through self care advice only. A third model was a nurse-led clinic for minor ailments that was available alongside all of the GP sessions in the practice. A fourth was

offering appointments with nurses and a clinical pharmacist as well as the GPs. The type of self care support included advice on taking up a self care skills training course, self care information, access to self care devices and equipment, or information on local self care support networks

GPs across the three practices saw quite different patient profiles, ranging from substantial numbers of minor ailments in one practice to mainly complex cases involving multiple morbidities in another.

Clinicians had different views about the extent to which they could incorporate self care into their own consultations. Some targeted particular consultations, particularly for self-limiting conditions. For long term conditions GPs tended to see nurse input as being the main mechanism through which self care was supported.

Some clinicians incorporated self care by asking the patient what they had done for themselves:

"I always ask what have you done, tried anything, taken anything, sought advice" (NP1)

When asked what they did to encourage self care if the same problem repeatedly happened in the future, some clinicians tried to encourage this:

"I work it in by talking about how to take care of the current illness – not blaming them to say 'you shouldn't have come today'" (GP3)

Nursing staff were actively involved in providing support for people to stop smoking and all the nurses had completed relevant training. One practice had a nurse-led weight management clinic and another was developing one.

Practices are actively developing the roles of nurses and Health Care Assistants with the intention of redistributing certain areas of work previously done by GPs. Patient education to transfer consultations to these other practitioners is ongoing and viewed as a long-term process. There was active signposting to different professionals within some of the practices.

"We're educating people to see non-GP staff. We've put a display in the waiting room with pictures of nursing staff and our Health Care Assistant to raise awareness of where people can go other than the GP" (PM1)

"Our receptionist suggests people see the practice nurse about minor ailments" (PN3)

"She (the clinical pharmacist) is very well qualified – our reception staff encourage people to see her. They ask "Do you think it's something our pharmacist could help with"" (PM3)

The acceptability of appointments with someone other than the GP was reported to be variable but in the practice which had operated nurse-led clinics for the longest time (three years), patient acceptability was reported

to have increased considerably over time. The staff in this practice reported that patients now know the most appropriate source for their appointment. While some patients have accepted and actively use the new service models, practices report that some continue to choose to see the doctor even where the practice staff feel it is not 'necessary'. The key outcome from people getting used to seeing care professionals other than doctors is that behaviours and habits of patients would change and self care support and advice would be more readily acceptable in the future, especially as the professionals in the new roles would spend a significant amount of their time providing support for self care.

In urgent care settings all participants agreed that there was considerable scope for more self care, particularly in minor ailments.

"Work was done on self care in 1999 and we (A&E) had about 40-50% of people with musculoskeletal, GI, skin, pain, coughs and colds, and hay fever. We're going to be repeating this work in a few weeks" (AEC2)

"We also see people in the clinical decision unit where self care support is very important, for example people with asthma who haven't been using their inhaler and are having an asthma attack" (AEC2)

The role of other staff in general practice

The practices visited had each created a Health Care Assistant (HCA) equivalent post, and were actually called 'Health Care Assistant' in some cases. The extent to which HCAs were involved in supporting self care was variable. All were involved in the process of 'new patient checks' when registering new patients with the practice and it was clear that this offered opportunities to raise and discuss self care.

"I check height, weight, blood pressure, ask about smoking and alcohol and regular treatments" (HCA 2)

The prior experience of many HCAs included practice reception work and hospital background. The self care skills training needs were therefore variable.

"I've been building up my knowledge of lifestyle" (HCA 1)

Another HCA had qualified to provide stop smoking advice and was due to undertake training to run a weight management clinic. In relation to stopping smoking:

"I say (to new patients) come when you're ready to come in . . . it's better if people do it (decide to stop) in their own time" (HCA 2)

The HCA role seems to offer considerable potential in supporting self care; training is likely to be easily accessible by practices. The practices were aware of some local courses, though relevance to the work was not always

apparent. Practice nurses are clearly playing an important part in mentoring and overseeing the development of HCAs but as one said:

"She's sat in on some of my consultations . . . but they're not necessarily at the level she needs to work at . . . mine might be in too much depth" (PN2)

Assuming relevant HCA training is available, dissemination of information to practices could increase the involvement of HCAs in supporting self care.

Provision of self care information to patients

Summary

In general practice, self care information was sometimes provided during consultations and was also available in the practice waiting room. Patient leaflets are printed by clinicians during some consultations. GPs and nurses had varied views about the usefulness of the leaflets included in their computer system. Barriers to the routine use of leaflets included concerns about whether they were up to date. Barriers in terms of lack of appropriate skills among patients in using leaflets included giving patients 'too much' information and about worrying patients by giving information that might be frightening and perhaps not relevant.

Most clinicians generally did not suggest or recommend use of the internet to patients for self care. Clinicians did not have a list of relevant websites but most thought it might be useful to have one.

Walk in Centres tended to report having a wide range of self care information leaflets available on specific conditions. In A&E the leaflets available were reported to focus on injuries.

The two main ways in which information was offered to patients were specific information during consultations and the availability of information in the waiting room.

Written information

All of the practices had a range of leaflets in the waiting room, some of which dealt with aspects of self care. Patients could help themselves to leaflets but clinicians did not refer to them in their responses concerning the use of written information. In general, practices did not have a systematic way of planning which information leaflets would be offered:

"We get sent leaflets in the post, we look at them and decide whether to use them" (PM2)

Displays on noticeboards were generally seasonally related. One practice said that they were:

"Developing a plan for topics to tie in with national days and programmes, with each display lasting for 4-6 weeks" (PN2)

Clinicians reported that they sometimes printed specific self care leaflets from the computer during some consultations. One GP, one practice nurse and a clinical pharmacist did this routinely.

GPs and nurses had varied views about the usefulness of the leaflets included in their practice computer system or PRODIGY leaflets that they accessed on the internet. In general, nurses were more positive about giving information leaflets to patients and reported more examples of doing so. The use of leaflets tended to be individual to the clinician and targeted, for example, for mothers of children with specific childhood infections.

"I use some EMIS leaflets - on common infections - measles, mumps" (GP3)

Barriers to the use of leaflets included concerns about whether they were up to date, about giving patients 'too much' information, about worrying patients by giving information that might be frightening and perhaps not relevant, about patients not having the right self care skills to use them.

"I don't use them much - I think they can be worrying" (GP2)

"You can give too much information" (GP1)

One GP, referring to the same leaflets that were used by another GP in a different practice, said:

"For example the chicken pox leaflet - the third thing it mentions is meningitis - it's worrying for parents" (GP4)

Some GPs felt that they would only regularly print leaflets for patients if they themselves had read all of them and were happy with their content.

"Unless I've actually read the leaflets I don't feel confident in their content" (GP2)

In two of the practices in-house self care leaflets had been developed by nursing and pharmacy staff to address the perceived issues around existing leaflets. One practice had focused on mental health (leaflets on depression, stress and anxiety) and the other on self-limiting conditions dealt with in the nurse-led clinic.

Some clinicians did not have access to a printer in their consulting room and this was a practical barrier to producing self care information during a consultation. However practical issues were not the only barrier in this case.

"If I could print them from my computer I might use PRODIGY leaflets - but how up to date are they?" (PN2)

The time taken during a consultation to find and print a relevant leaflet was also an issue. One nurse practitioner printed selected leaflets in advance to minimise the time spent on this in the consultation:

"I pre-print certain EMIS leaflets - on asthma and on minor ailments - backache, tonsillitis, earache" (NP1)

For leaflets obtained by practices from external sources there were perceived difficulties in sourcing and sustaining stocks. Local health promotion departments were viewed as an important source but quantities were restricted and:

"We might get (a good leaflet) for a few months but then we can't get it again" (HCA2)

The NHS Direct 'Not Feeling Well' resource was not widely used by the practices. Clinicians and practice managers recalled seeing copies of the original booklet but were generally unsure about how to get copies of the current version. One practice had copies in the waiting room and in consulting rooms but clinicians did not report using it in their consultations. Clinicians and other practice staff were not aware that Thomson's Directory at one time contained 'Not Feeling Well' and therefore they were not actively recommending patients to use it at home.

One clinician mentioned the issue of availability of resources for people whose first language was not English and for people with learning disabilities:

"Visual resources would be useful but I don't know where to get them" (PN1)

One participating GP had developed a collection of books and provided them on loan to patients as a type of 'prescription'. This was based on work from the US which was later also implemented in Wales. The practice which was interviewed in the survey was developing 'information prescriptions' for patients. The list of books was to be made available on the practice computer with a drop down menu of topics and titles. Books were assessed by clinicians for their suitability and then included in the scheme. The practice had employed a Community Health Support Officer when it was first opened but had discontinued the post due to funding problems following the introduction of nGMS.

Within unscheduled care settings Walk in Centres reported having a range of leaflets which included self care information.

"We have health information racks and leaflets on specific conditions - chronic back pain, ear infections, throat infections" (UCM3)

This Walk in Centre had developed leaflets on the most commonly presented conditions, all of which had self care content.

A&E departments reported having fewer leaflets and there was an emphasis on follow on care for certain injuries.

"The only leaflet (in the main A&E area) is one about different conditions and available services. Our ENPs have leaflets about self care following fractures etc" (AEC2)

"We have a series of leaflets on injuries and some on health promotion (drug use, HIV) but none on minor ailments" (UCM2)

The internet

Three of the 12 clinicians interviewed in general practice (one GP, one practice nurse and a clinical pharmacist) said that they regularly recommended use of the internet to patients for supporting self care.

"I ask if they have access to the internet and I recommend certain sites, for smoking cessation, Diabetes UK, basic information about exercise, that sort of thing" (PCP1)

"We would probably gauge where to direct patients to. The practice would always want to go for evidence based information. We like BestTreatments, and the British Hypertension Society website, for example, for patients who want to buy a blood pressure monitor" (PCP)

The GP described how he conducted short internet searches during consultations and printed out material for patients.

"I've become more adept at finding information quickly during consultations. I check if they have internet access. I might print the Google front page and circle certain references" (GP5)

Practice nurses sometimes recommended a travel health website, and one recommended a website on nutrition with recipes for healthy eating to some patients with diabetes. One practice nurse said she regularly asked patients if they had access to the internet.

One reason cited by clinicians who did not recommend internet sites to patients was uncertainty about the quality and relevance of available sites.

Clinicians did not have a list of relevant websites but most thought it might be useful to have one.

Staff in urgent care settings did not recommend websites as a resource. Reasons suggested were that patients were unlikely to have access to IT, although it was unclear whether staff routinely asked about this.

Information for staff

There were few examples of sharing of information across staff. In one practice the clinical pharmacist had produced a list of available over the counter medicines for certain conditions together with suggested duration of use. A copy of this list was available in each consulting room in the practice.

Referral to self care support resources

Summary

The practices did not have a central list of self care support resources, local or national organisations, community or voluntary networks. Referrals and information-giving were mostly based on Individual clinicians maintaining a list of contacts.

Referral to voluntary patient organisations was not common. Some clinicians used a list in the practice computer system. GPs tended to expect that during their clinics for long term conditions such as diabetes and asthma, nurses would discuss patient support groups and local self care support networks.

Knowledge about local self care support resources was variable. There appeared to be no mechanism to share this within the general practices. Some resources were not initially identified by staff as relevant to supporting self care so links were not always made.

Clinicians mainly referred patients to the pharmacist when a medicine was cheaper over the counter. There was concern about putting financial pressure on patients who were exempt from prescription charges and this limited the number of people who were referred on to pharmacists.

Clinicians expressed support for EPP and some said they referred patients to the programme. Knowledge and understanding of EPP was variable. A barrier to increasing engagement and referrals was, in some cases, lack of information and some uncertainty about which patients should be referred to the programme. Other clinicians had a good understanding of EPP and were keen to promote it. Barriers to doing this was the time it takes to explain about EPP during a consultation with a patient, and lack of knowledge about dates & locations for courses. There were also some practical issues around awkwardness of venues for EPP and difficulties for patients reliant on public transport.

Some clinicians were aware of disease specific self care skills training courses such as Dafne, Desmond, D-STEP or LAD for people with diabetes. There were barriers to making them available or referring to them more frequently in terms of the time it took to explain about the courses and the lack of knowledge about dates and locations of courses.

Clinicians took a cautious approach to complementary therapies. None recommended specific complementary therapies. If a patient told them they wanted to try a treatment, clinicians said they would not discourage this.

Local and national self care support resources

Practices did not keep a central list of self care support resources, community or voluntary networks or agencies. Information-giving and referrals were based on Individual clinicians maintaining a list of contacts.

"I've put together a list of patient organisations and a health events calendar" (PN2)

Some clinicians were aware of a list of national patient organisations in the practice's computer system.

"The common patient organisations are listed on EMIS" (GP3)

However the list was not routinely used by most clinicians. Some GPs saw self care support resources as something that fell within nurses' territory and expected that, during the clinics for long term conditions such as diabetes and asthma, nurses would discuss patient support groups and local community self care support networks.

One GP referred to self care support groups as a routine part of consultations, looking them up on the internet with the patient.

Knowledge about relevant local resources, for example, those provided by the local council, was variable.

*"We've got bits and pieces but they're not brought together" (*PM1)

One GP said he occasionally referred older people to a local 'Café Club' which provided support for isolated elderly and other resources such as Tai Chi classes. Clinicians in another practice regularly referred people with diabetes for the locally run 'Learning About Diabetes' programme. Some clinicians said they were aware of other self care skills training courses such as Dafne, Desmond or D-STEP for people with diabetes but found there were barriers to making them available or referring to them more frequently in terms of the time it took to explain about the courses and the lack of knowledge about dates and locations of courses.

While practices did not have a policy or protocol about recommending use of different resources to support self care some participants were following certain principles. For example, staff in one practice expressed a concern about recommending resources that the patient would have to pay for:

"Nothing that people would have to pay for, such as keep fit classes" (PM2)

"We have limited access to exercise on prescription" (PN1)

In one practice the shared knowledge of individual clinicians and the practice manager was quite extensive but there was no mechanism to spread this within the practice. These sorts of resources (for example free

swimming sessions for people with arthritis) were not initially identified by staff as relevant to self care support.

When asked whether access to a shared list of an integrated self care support resource would be of value most participants thought it would be and one GP suggested that it could be done on behalf of a cluster of practices by the PCT.

"This could be done via the PEC" (GP1)

Local pharmacists

Most of the participants thought that community pharmacists potentially had a greater role to play in supporting self care.

"I don't think they utilise the pharmacist" (PN4)
Clinicians in general practice sometimes referred patients to the pharmacist and this was most likely when the patient paid prescription charges and a medicine was cheaper over the counter.

"I tell them to buy aspirin over the counter if they pay for their prescriptions. Also self-treatment of colds" (PN2)

There was, however, concern about putting financial pressure on patients who were exempt from prescription charges and this limited the number of people who were referred to the pharmacy.

"So many people are exempt – why should they buy it (over the counter treatment)? " (PM2)

The practices appeared to have little actual contact with local pharmacists and there was no forum for practice clinicians and pharmacists to discuss support for self care.

In one practice the clinical pharmacist had produced a list for the local pharmacists for which treatments the practice used for certain minor ailments, and duration of treatment.

"Pharmacists need to be in the loop with other care providers" (PCP1)

Self care skills training courses

Most of the clinicians in general practice were aware of, and expressed support for, the Expert Patients Programme course and some said they referred patients to the programme.

"When it first came out I picked people to recommend it for, less so recently" (PN2)

"It's really good when you can get patients to go on it" (PM2)

Knowledge and understanding of EPP was variable. One practice had run an EPP course in their premises but found that the facilities were not really suitable because they did not have a sufficiently large room. The practice manager was a strong advocate for EPP because a family member had attended and had found it very valuable. She therefore had a direct source of information about its benefits.

Barriers to increasing referrals to EPP were, in some cases, lack of information and some uncertainty about which patients should be referred. Guidance from the PCT was expected by some:

"A lack of information from the PCT about which patients they want" (GP3)

Other clinicians had a good understanding of EPP and were keen to promote it. A barrier to doing this was the time it takes to explain about EPP during a consultation with a patient.

"It's hard to explain – to get over what patients can gain from it. Difficult to put into words and I class myself as someone who's been more in touch with it." (PN2)

There was no easily accessible source of dates and venues that could be used during consultations. Some practice staff felt unengaged with EPP:

"It's a phone number on a poster, not through the practice" (HCA 2)

There were also some practical issues around awkwardness of venues for EPP and difficulties for patients reliant on public transport.

Some clinicians said they were familiar with disease specific self care skills training courses such as Dafne, Desmond, D-STEP or LAD for people with diabetes. But there were barriers to making them available or referring to them more frequently in terms of the time it took to explain about the courses and the lack of knowledge about dates and locations of courses.

<u>Complementary therapies</u>

Clinicians took a cautious approach to complementary therapies. None recommended specific complementary therapies and they did not ask patients about them. If a patient told them they wanted to try a treatment clinicians said they would not discourage this.

"People with long term conditions sometimes want to try it. If it works, OK" (PN1)

"Try to be helpful to patients and not just dismiss it if they want to try it – but if we felt it would be dangerous we'd say so" (PCP1)

In general, clinicians were sceptical about the effectiveness of complementary therapies and some said they would tell a patient this if they were asked:

"If I was asked for an opinion I'd say it was not evidence based" (PN2)

Support for carers

One practice had an active programme in collaboration with local carer support to identify carers including signs in the waiting room and on the electronic display saying "Are you a carer? Have you collected your goodie bag?" The goodie bag contains a range of information leaflets about resources for carers and details of local carers' support. The practice, when giving out the bags, asked if they could enter details onto their carers' register and also for consent to share this information with local carer support. This provided an opportunity to build local self care support networks.

Staff training in self care

Several participants in general practice had completed training that was relevant to supporting self care although none had training specifically by the name 'self care'. Some nursing staff had qualifications in health education and saw this background as very relevant to supporting self care. However a need for further training was also identified:

"It needs a course in its own right" (NP1)

Some participants were unclear what training might be available:

"Lack of availability or not knowing how to find any available course, especially for HCAs for whom self care support would be highly relevant." (PN2)

Transferable skills from other training was mentioned by several people in relation to smoking cessation and understanding differences in readiness to change behaviour.

One HCA had recently completed an 'Introduction to Obesity' course provided by the local health promotion unit as part of her 'personal development plan' to run a weight management clinic.

In urgent care settings there were a few examples of self care training having been undertaken by staff, or of training policies that included self care.

"One week's training for our (A&E) staff, provided by our GP co-op" (UCM2)

"The Stopsley minor ailments course – most of our (WiC) nurses have done that" (UCM3)

Participants from urgent care settings had suggestions about what sort of training would be effective:

"When minor ailments are taught the concept of self care and of handing back to the patient needs to be integral to the training" (AEC1)

"ENPs could be seconded to GP surgeries to learn how GPs provide self care support for people who come with minor ailments" (UCM2)

"Staff can learn from each other – those from secondary care can learn more about self care from people working in primary care" (AEC1)

"We intend that all of our (WiC) staff will be dual trained (in minor injuries and minor ailments)" (UCM3)

Feedback from patients about self care support

Clinicians received little feedback from patients about how the practice provided support for self care. Although there is potential to include a topic such as self care in surveys, the patient surveys that practices conduct for their QOF requirements do not currently include self care:

"We use one standard questionnaire and it's (self care) not covered" (GP3)

One practice that had introduced an 'Express Clinic' for minor ailments had conducted a patient survey specifically on this service.

3. CONCLUSION

There is a high level of support among general practice staff for an NHS policy of supporting and promoting self care and most of the participants in this study identified considerable scope to increase support for self care.

Although self care work is going on in practices it is not currently a systematic part of most consultations nor is it subject to practice-wide policies. The finding from the 2005 DH self care baseline study that *"… half of those who have seen a care professional in the previous six months say they have often been encouraged to do self care, but a third say they have never been encouraged by the professionals"* is reflected in the reported self care support activities of the clinicians in this study[3].

General practice and urgent care staff perceived several barriers to supporting self care. Concern that the message about people doing more for themselves was potentially contradicted by the message about people's right

[3] *Public Attitudes to Self Care – A Baseline Survey*. Department of Health, February 2005.

to rapid access to primary care in the access target was a common theme. Raising self care skills of the public was seen as a potential solution to this paradox. Practice staff saw the need for a co-ordinated effort involving central (DH), local and practice level inputs to address this.
There appears to be a need for more support for teams working in general practice and urgent care settings to develop coherent policies and protocols on self care support. Awareness of patient organisations and local resources was low. Appropriate training for professionals in self care support also appears to be an issue across all settings. Again there is resonance with the conclusions of the DH baseline study with the public[3]:

"If professionals are to play an active role in self care, more work needs to be done with them to develop their role in supporting self care. Skills training would be key, as change may require culture shift from professionals being the principal providers of care and patients as passive recipients, towards more emphasis on shared care, preventive care, healthy lifestyle and patient involvement in their own care of minor, acute and long term conditions – with professionals providing a supportive, advisory, educational and skills training role".

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EDITORIAL TEAM

The concept for the project was designed by Ayesha Dost, the interview schedule was developed jointly by Ayesha Dost and Alison Blenkinsopp.
AB carried out most of the interviews and data analysis. AB and AD produced the final report.